

# 2013 Employee Benefit Guide



**NAVIGATE  
YOUR  
BENEFITS!**





# Table of Contents

**A**s an employee with the City of Arlington, you will need to make a number of important benefit decisions within 30 days of your full-time employment and annually thereafter. This booklet provides a summary of the benefits offered by the City. Additional benefit information, documents, links and forms are included on the Workforce Services portal and we strongly encourage you to review the plan documents prior to making your benefit plan selections.

Medicare “Notice of Notice” .....	3
2013 Benefit Plan Updates .....	4
Initial Notice of Your HIPAA Special Enrollment .....	4
Employee Eligibility .....	5
Dependent Eligibility.....	6
Dental Insurance .....	7
Income Protection Plans .....	8
• Term Life and Accidental Death & Dismemberment Insurance	
• Long-term Disability Insurance	
Medical Plans .....	9
Vision Insurance .....	13
Flexible Spending Accounts (FSA) .....	14
Individual Health Savings Account (HSA).....	17
Retirement Plans - 401k, 457, TMRS.....	18
Life Changes Requiring Health Choices...Know Your Benefit Options.....	19
Employee Assistance Plan (EAP) .....	21
Additional Voluntary Plans.....	22
• Cigna Short Term Disability	
• MetLife Critical Illness	
• SISLink Medical Gap	
Glossary of Health Coverage and Medical Terms .....	23
Required Notices	
COBRA Initial Notice .....	27
Pharmacy Creditable Coverage Notice.....	29
United HealthCare Annual Rights and Resource Disclosure Notice.....	31
Health Care Reform Required Notices.....	32
CHIPRA Notice.....	34
Appendix	
A - Plan Rates & Contribution Limits - TMRS & PST/DIP Required Contributions.....	36
B - Optional Life Insurance Rates .....	37
C – Other Voluntary Plan Rates.....	39
Important Contacts .....	40

**MEDICARE NOTICE: If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you choices about your prescription drug coverage. Please see page 29 for more details.**

*Warning: Any intentional false statement in your enrollment or willful misrepresentation relative thereto is a violation of City policy subject to disciplinary action and/or financial restitution. The Patient Protection and Affordable Care Act (“PPACA”), which was signed into law in March 2010, prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact.*

# 2013 Benefit Plan Updates

Welcome to the City of Arlington. This document is intended to give you basic information about benefit plan options available to you. The information contained in this guide should in no way be construed as a promise or guarantee of employment or benefits. The company reserves the right to modify, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this guide and the actual plan document or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies, and plan documents available on the Workforce Services portal.

This Benefit Guide highlights recent plan design changes and is intended to provide you with a Summary of Material Modifications. **In 2013, the City will Incorporate the following plan modifications:**

## A. Medical Plans

1. The Annual Deductible for the Core & Plus Medical Plans will go toward meeting the annual out-of-pocket maximum.
2. The annual out of pocket maximum for the Core & Plus Medical Plan will be \$5,000 individual and \$10,000 family.
3. The pre-existing exclusion clause for adults has been removed (this exclusion was removed for children effective 1/1/2012).
4. Additional preventive services will be covered at 100% when they are delivered by an in-network provider and they are included as eligible by the U.S. Preventive Services Task Force
5. Bariatric surgery will be limited to one procedure per lifetime. This limit includes when a procedure doesn't work and another procedure is recommended by your physician. Example: have bypass surgery and then physician recommends lap band - the lap band surgery would not be considered an eligible expense under the plan.
5. 2013 rate changes are included in Appendix A, page 34 of this guide.
6. A Summary of Benefits and Coverage (SBC), which summarizes important information about the health plan coverage options is available on the Workforce Services portal, city website [www.arlingtontx.gov](http://www.arlingtontx.gov) under Retiree benefits, or you may request a paper copy free by calling 817.459.6869.

## B. Prescription Plan

Effective 1/1/2013 the plan will provide 100% coverage for eligible contraception when delivered by an in-network provider and they are included as eligible by the U.S. Preventive Services Task Force.

## C. Flexible Spending Account

The IRS has established a \$2,500 annual maximum for Health & Limited Scope FSA accounts effective 1/1/2013. NOTE: Any roll over funds remaining in your FSA account on 12/31/2012 will not count toward your 2013 election.

## Initial Notice of Your HIPAA Special Enrollment Rights

**Loss of Other Coverage** - If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. **You will be required to submit a signed statement that this other coverage was the reason for waiving enrollment originally.** To be eligible for this special enrollment opportunity you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

**New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption** - If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

**Medicaid Coverage** - The City of Arlington group health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. **TERMINATION OF MEDICAID OR CHIP COVERAGE**- If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. **ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP**- If the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than provide direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

**Note:** The 60 day period for requesting enrollment

applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30 day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Workforce Services at 817.459.6869. Also refer to "Life Changes Requiring Health Choices...Know Your Benefit Options" on page 19 for additional information.

## Employee Eligibility

As a full-time employee, you are eligible to enroll in the benefit plans described in this guide. When you have completed your on-line enrollment through Employee Self Service within the required 30 days, your coverage begins your first day of full-time employment for medical, dental, vision, optional life and accidental death & dismemberment insurance, or flexible Spending Account(s). Health Savings Account (HSA) payroll deducts will begin only after verification of your individual bank account number. *Full-time employees are automatically enrolled in city-provided basic term life insurance, long term disability and the employee assistance (EAP) plans.*

Payroll deductions will begin for your benefit elections retroactive to your first day of employment. If your enrollment is not completed within the 30-day time period, you will have no elective benefit coverage for the remainder of the plan year; but you may enroll during the annual open enrollment period for coverage the following year. Refer to the special enrollment / change in family status sections for mid-year election change criteria.

You are encouraged to designate and update

beneficiary information in Employee Self Service for your life insurance coverage and other plan assets as needed.

### Social Security Number Required

As of January 1, 2009, the Centers for Medicare and Medicaid require employers to obtain the Social Security number (SSN) for all family members enrolling in City benefits.

### Medicare Card Requirement

The Centers for Medicare and Medicaid have established coverage rules to determine which plan is considered primary and secondary when an individual becomes eligible for Medicare. Eligibility may be due to a disability prior to age 65 and/or attainment of age 65. Benefits under the City's plans may be reduced when you or a covered family member become eligible for Medicare based on Federal regulations.

It is the employee's responsibility to notify Workforce Services of any covered family member's eligibility for Medicare and to provide a copy of the individual's Medicare card.

# Dependent Eligibility

## Who is considered an eligible dependent?

Eligible Dependents	Documentation Required for Enrollment	Due Dates
Spouse	<ul style="list-style-type: none"> <li>• Marriage License</li> <li>• Most Recent Joint Tax Return</li> <li>• Informal Marriage Form</li> </ul>	30 days
*Child / Stepchild	<ul style="list-style-type: none"> <li>• Birth Certificate</li> </ul>	30 days
*Other Dependent Child	<ul style="list-style-type: none"> <li>• Court order for Guardianship or Conservatorship signed by a Judge</li> </ul>	30 days
*Adopted Child	<ul style="list-style-type: none"> <li>• Adoption Documents &amp; Birth Certificate</li> </ul>	30 days
*Child Placed for Adoption	<ul style="list-style-type: none"> <li>• Placement Documents &amp; Birth Certificate</li> </ul>	30 days
*Qualified Medical Support Order	<ul style="list-style-type: none"> <li>• Notification from State Attorney General</li> </ul>	As directed by AG's Order
*Other Medical Support Order directed to the City of Arlington	<ul style="list-style-type: none"> <li>• Copy of Court Order to City of Arlington</li> </ul>	30 days
A Child incapable of self-sustaining employment due to a mental or physical disability if the child was enrolled in the City medical plan the day before the child attains age 26.	<ul style="list-style-type: none"> <li>• Attending Physician Statement</li> </ul>	30 days
*Dependent must be less than 26 years old		

NOTE: It is the employee's responsibility to drop coverage for a dependent no longer eligible for a City plan. If a dependent becomes ineligible, an enrollment change is required within 30 days. The employee is responsible for reimbursement of all benefit payments made or coverage provided for an ineligible dependent. If at any time an ineligible dependent is enrolled in coverage or remains enrolled in coverage when they are not eligible for the coverage, the employee is fully responsible for all IRS tax implications (including penalties assessed by the IRS). The employee will be required to reimburse the City for all contributions made on behalf of an ineligible dependent. If you fail to make the coverage change within the required time frame, the dependent remains ineligible for benefits, however, your payroll deductions will not change for the remainder of the plan year. It is also your responsibility to ensure you drop ineligible dependents during the next annual open enrollment period (effective the following Jan. 1.)

You may **not** be enrolled as an employee **and** a dependent in any City of Arlington plan. Example- You and your spouse are both employed in a benefit eligible position with the City. You may not enroll him/her in spouse life coverage. When both spouses work for the city, only one employee may enroll dependent children for child life.

Employees must always include social security numbers in Lawson under personal information to enroll.

When you enroll in the online enrollment system, you will attest that you understand the definitions for dependent eligibility and only eligible dependents have been enrolled in any plan.

*"I affirm that my benefit enrollment includes only those dependents that meet the City of Arlington eligibility guidelines. Providing dependent information that is false and/or inaccurate, or enrolling dependents that do*

*not meet eligibility guidelines can result in disciplinary action up to and including termination of coverage and/or employment"*

## Annual Audit of Selected Employees

Audits of employees may occur at any time. Employees will be required to provide documentation proving eligibility of covered dependents. Those contacted will receive a list of acceptable documentation based upon the type of dependent enrolled. If sufficient documentation is not provided within a 30 day period, coverage will be dropped and/or denied. Providing false or inaccurate dependent information may result in disciplinary action, up to and including termination of coverage and/or employment. This process is intended to confirm that you have enrolled only qualifying family members under the terms of the benefit plans.

# Dental Plans

The City's dental coverage is administered by MetLife Dental. You may choose one of three dental plans:

- A Dental Health Maintenance Organization (DHMO) plan that requires you to select an in-network provider before seeking dental services. Providers are located exclusively in Texas. If you move out of Texas, you must notify us within 30 days to drop coverage or change to one of the PPO plans.
- Two Preferred Provider Organization (PPO) dental plan options that allow you the freedom to select any

dentist. However, in-network providers will typically charge a lower fee for services.

Refer to the Dental Plan Comparison Chart below and the coverage summaries included on the Workforce Services portal for the schedule of benefits and additional plan details. Call 1.800.942.0854 for assistance with selecting a dentist or to request a provider listing.

See Appendix A for bi-weekly rates.

## DENTAL PLAN COMPARISON:

Plan Feature	DHMO Plan (In-Network dentist selection required)	Low PPO Plan (In- or Out-of-Network)	High PPO Plan (In- or Out-of-Network)
<b>Deductible</b> (calendar year)	None	\$50 per person/Maximum \$150 (\$50 x 3)	\$50 per person/Maximum \$150 (\$50 x 3)
<b>Preventive care:</b> one visit every six months for a routine checkup, cleaning and polishing *	Plan pays 100% after \$5.00 appointment co-pay for in-network dentist only.	Plan pays 80% of eligible dental fees. Deductible does not apply.	Plan pays 80% of eligible dental fees. Deductible does not apply.
<b>Basic care:</b> fillings *	You pay a fixed co-pay according to the plan schedule for in-network dentist only.	Plan pays 60% of eligible dental fees after deductible is met.	Plan pays 80% of eligible dental fees after deductible met.
<b>Major care:</b> bridges, dentures *	You pay a fixed co-pay according to the plan schedule for in-network dentist only.	Plan pays 50% of eligible dental fees after deductible is met. Waiting periods may apply.	Plan pays 50% of eligible dental fees after deductible met. Waiting periods may apply.
<b>Maximum annual benefit</b>	No limit	\$750 per person	\$1,500 per person
<b>Orthodontic care</b>	See fee schedule (adults & children under age 26)	No coverage	50% with a lifetime maximum of \$1,000 (children under 19 only)
<b>Implants</b>	No coverage	Plan pays 50% of eligible	Plan pays 50% of eligible

\*Refer to schedules and summary plan descriptions found on the Workforce Services Portal or the MetLife Dental website [www.metlife.com](http://www.metlife.com).

# Income Protection

See Appendix B for rates.

When you consider your coverage options, you should think about those who might be affected by your disability or death.

If you:	This policy:	Pays benefits to:
Die	Life Insurance	Your beneficiary
Die in an accident	Life Insurance and AD&D Insurance	Your beneficiary
Suffer a covered dismemberment	AD&D Insurance	You
Become disabled	City provided long-term disability and possibly AD&D (if disability is because of dismemberment)	You

## Eligibility

All full-time employees of the City of Arlington are provided with basic term life insurance and long-term disability coverage. You may also choose to purchase additional optional life and accidental death & dismemberment insurance for yourself and life insurance for your spouse and/or child(ren).

## Basic Term Life Insurance for You

The City of Arlington provides Basic Term Life Insurance coverage at two times your base annual salary up to \$300,000 at no cost to you. You may add to this coverage by electing optional life and accidental death & dismemberment insurance coverage. Life insurance coverage will reduce to 65% at age 70, 55% at age 75, 30% age 80 and over.

## Evidence of Insurability (Eol)

An Evidence of Insurability is a health questionnaire which must be completed if you are required to provide proof of good health. All questions must be answered fully and completely. Incomplete information will delay the processing of any coverage request. Enrollment in life insurance amounts that require an Eol during the annual open enrollment must be completed and returned to Workforce Services no later than 5 p.m. December 31, 2012. Eol forms requesting coverage increases based on the annual enrollment will not be processed after that date.

Payroll deductions for enrollment amounts that require approval are not effective until approval notification has been received from Cigna. Workforce Services will automatically increase your coverage amount and start your payroll deduction once an approval is received.

See Appendix B for Optional Life Insurance Rates.

## Optional Term Life and Accidental Death & Dismemberment Insurance for You

As a new employee, you may elect coverage in \$10,000 increments, up to eight times your base annual salary (minimum enrollment of \$20,000) but not more than \$200,000 (up to \$500,000 with an approved Eol). You pay premiums on a post-tax basis, therefore life insurance proceeds paid to your beneficiary are not taxable to them. If you do not elect optional coverage within 30 days of your first day worked, Eol will be required by the life insurance carrier for review/approval of all coverage enrollment/elections. Employees have the opportunity to complete the Eol once each year during the City's annual open enrollment period.

Life insurance coverage amounts will reduce to 65% at age 70, 55% at age 75, 30% age 80 and over.

## Supplemental Dependent Term Life Insurance

**Note:** Employee must first be enrolled in Optional Term Life Insurance and Accidental Death & Dismemberment to enroll in the spouse/child life insurance plan. Dependent coverage is contingent upon the dependent not being home or hospital confined for medical care or treatment.

This coverage pays life insurance proceeds to you in the event your spouse/child dies.

As a new employee, you may elect coverage for your spouse in \$5,000 increments up to 50 percent of your Optional Term Life Insurance coverage, but not more than \$150,000 (minimum \$10,000). Elections above \$50,000 will require the completion of an Eol.

You may elect coverage of \$10,000 for your children under the age of 26. If you do not elect coverage within 30 days of your first day worked, an Eol will be required by the life insurance carrier for review/approval of all coverage enrollment/elections. Spouse coverage ends at age 70.

## Guaranteed Issue for a New Employee

As a new employee, the guaranteed issue is the maximum amount of coverage that may be elected without an Eol. If you select a coverage amount above the guaranteed issue amounts shown below, you will need to complete an Eol found on the Workforce Services Portal under the Life Insurance Category.

Employee Basic Life .....	\$300,000
Employee Optional Life and Accidental Death & Dismemberment .....	\$200,000
Spouse Optional Life .....	\$50,000
Child Optional Life .....	\$10,000

*Note: Eol is required for all coverage amounts declined by the life insurance carrier previously.*

## Additional Purchase

**Once enrolled** for Optional Life, each annual enrollment employees may elect to add or increase coverage up to \$50,000 and they may add or elect to increase their spouse coverage by completing an Evidence of Insurability form for review by the insurance company. Payroll deductions for any coverage increase will not be set-up until the insurance company provides approval for the increase.

## Accidental Death and Dismemberment (AD&D) Insurance Coverage

Employees that enroll in the Optional Life Plan, you will automatically be enrolled in an equal amount of AD&D coverage. AD&D pays benefits if death or a covered dismemberment. If you are injured as a result of the accident, you may be eligible to receive a benefit. (Refer to AD&D schedule of benefits located on the Workforce Services Portal.)

## Long-term Disability Insurance Benefits

The City of Arlington provides a disability benefit for 60 percent of your base monthly pay at no cost to you. The minimum benefit is \$50 a month and the maximum is \$6,000 a month. The plan begins to pay benefits after a 120 calendar day waiting period. Benefit payments are taxable income to you.

Disability means you are under the care of a physician and:

- For the first 24 months, you must be unable to perform the essential duties of your own occupation.
- After 24 months, you must be unable to perform the essential duties of any occupation for which you are reasonably qualified by education, training, or experience.

Long-term disability benefits are reduced by other sources of income during disability such as Workers' Compensation, Social Security, Texas Municipal Retirement System and other benefits.

# Medical Plan Options

## IMPORTANT INFORMATION

Participants may not change plans due to a life event as a result of retirement, return from unpaid leave, birth of a child, marriage, divorce, etc.... Example: January 1 you elect to enroll in the Plus Medical plan. You retire from the City effective March 31. If you continue medical coverage as a retiree, you must remain enrolled in the Plus Medical plan for the balance of the calendar year.

## Life Event Coverage Level Changes for the Value Medical Plan

Before you enroll in the Value plan, you should be aware of how the deductible will work as a result of a coverage level change (Single to Family OR Family to

Single) for the balance of the plan year. Here are some examples of what to expect:

Example 1: You and your spouse enroll in the Value plan effective January 1. From January through March your claims equal \$500 and your spouse's claims equal \$2,500 to meet the \$3,000 Family deductible. You are now paying 10% of eligible expenses. Effective April 1, your spouse is Medicare eligible and enrolls in Medicare and an AARP supplement plan. Your coverage level now changes from Family to Single. You have claims equal to \$500 of the \$1,500 Single deductible. You will have to meet your additional \$1,000 deductible before any benefits are paid. There are no claims reprocessed for which you have already received a benefit above the \$3,000 Family deductible.

Example 2: You increase your coverage level from Single to Family due to your marriage. You have already met the \$1,500 Single deductible. The Family deductible is \$3,000. You will have to meet the additional deductible before any benefits are paid.

The City of Arlington offers three medical plan options through UnitedHealthcare's Choice Network of physicians. The covered services and the network of providers are identical. All plans provide **in-network benefits only. Services received out-of-network are the full responsibility of the employee.**

Although a primary care physician is not required, you are encouraged to choose a primary care physician (PCP) from the UnitedHealthcare Choice network to coordinate your health care. Additionally, referrals are not necessary to see a specialist in the UnitedHealthcare Choice network.

#### **1. Core Plan** (Choice In-Network Providers/Facilities ONLY)

- \$1,000 per person, \$2,000 per family deductible
- Deductible must be paid before the plan will pay medical benefits (other than preventive care)
- Deductible is counted toward meeting the out-of-pocket maximum
- After the deductible has been met for the plan year, the plan pays co-insurance of 80% and participants are responsible for 20% of eligible expenses
- The co-insurance applies to all incurred medical plan covered services, whether at the physician's office, the emergency room, outpatient surgery, or hospital admissions.
- The maximum amount of co-insurance that you will pay on this plan is \$5,000 per person or \$10,000 per family
- The plan pays 100% of eligible preventive care services (not subject to meeting the deductible). Preventive services include services as defined by the United States Preventive Services Task Force. In 2013, birth control will be paid at 100% of eligible expenses.

#### **2. Plus Plan** (Choice In-Network Providers/Facilities ONLY)

- \$750 per person, \$1,500 per family deductible
- Deductible must be paid before the plan will begin to pay medical benefits other than preventive care)
- Deductible is counted toward meeting the out-of-pocket maximum
- After the deductible has been met for the plan year, the plan pays co-insurance of 80% and participants are responsible for 20% of eligible expenses.

- The co-insurance applies to all incurred medical plan covered services, whether at the physician's office, the emergency room outpatient surgery, or hospital admissions.
- The maximum amount of co-insurance that you will pay on this plan is \$5,000 per person or \$10,000 per family.
- The plan pays 100% of eligible preventive care services and are not subject to meeting the deductible. Preventive services include services as defined by the United States Preventive Services Task Force. In 2013, birth control will be paid at 100% of eligible expenses.

#### **3. Value Plan** (Choice In-Network Providers/Facilities ONLY)

- The Plan deductibles are \$1,500 for one person, \$3,000 for more than one person.
- IMPORTANT: Mid-year plan changes that reduce the coverage level from Family to Single may require the member to meet any portion of the Single deductible not already met by that member (\$3,000 to \$1,500).
- This plan qualifies as a High Deductible Health Plan (HDHP) as outlined by the Internal Revenue Code
  - **The deductible applies toward the out-of-pocket maximum**
  - Medical and prescription expenses are combined under this plan to meet the annual deductible
  - After the deductible has been met for the plan year, the plan pays co-insurance of 90% and the participant is responsible for 10% of eligible medical and pharmacy expenses.
  - **When enrolled for more than one person, the full family deductible amount of \$3,000 must be met by one covered family member or a combination of covered family members. After the deductible has been met, eligible benefits are paid at the 90% level. See page 9 for details when this coverage level changes mid-year.**
  - The co-insurance applies to both medical services and prescriptions.
  - The maximum amount of co-insurance that you will pay on this plan is \$5,000 for one person or \$10,000 for more than one person. When enrolled for more than one person, the full family out-of-pocket amount of \$10,000 must be met by one covered family member or a combination of covered family members before medical benefits are paid at the 100% level.
  - The plan pays 100% of eligible preventive care services (not subject to meeting the deductible). These services are based on the United States

Preventive Services Task Force guidelines. In 2013 birth control will be paid at 100% of eligible expenses.

- You may be eligible to open an individual Health Savings Bank Account (HSA). We encourage you to review IRS Publication 969 to determine if you are eligible to make contributions to an HAS bank account. Go to [www.irs.gov](http://www.irs.gov) before you enroll to review the IRS eligibility criteria.

### Medicare Coverage:

If you or any of your family members are eligible for Medicare, covered by Medicare, or become eligible/covered by Medicare, it is YOUR responsibility to notify Workforce Services immediately by providing a copy of the Medicare card. Typically the City's coverage for an active employee (and their family members) will be the primary plan. However, coordination of benefits is determined by Medicare laws and there are situations when Medicare may become the primary coverage even when you are an active employee. Medicare is typically the primary plan for retirees. Refer to [www.medicare.gov](http://www.medicare.gov) for additional information regarding coordination of benefits with group health plans.

## Pre-Existing Condition Exclusion Clause

There are no pre-existing conditions exclusions for dependent children or adults under any of the medical plans offered by the City of Arlington effective January 1, 2013..

**See Appendix A for Benefit Plan Rates.**

When considering the Value, Core and Plus Plans, **it is important to remember that the participant is responsible for paying the deductible amount before any benefits will be paid toward medical care other than preventive care services.** The plan pays 100% of eligible preventive care services. These services include, but are not limited to well baby/child care, well woman care, and annual physicals and eligible birth control expenses.

## Prescription Drug Plans

The prescription benefit is the same for both the Core and Plus plans - a 4-tier structure where you are responsible for a percentage of the total drug cost.

**Typically**, Tier 1 will include generic or very common drugs, Tier 2 will include preferred name brand drugs, Tier 3 will include non-preferred name brand drugs, and Tier 4 will include specialty drugs.

Tier	Example Cost	EE Pays	% EE Cost	Health Plan Pays	Health Plan Cost
1	\$ 30.00	15%	\$ 4.50	85%	\$25.50
2	\$ 95.00	25%	\$28.75	75%	\$71.25
3	\$200.00	40%	\$80.00	60%	\$120.00
4	\$760.00	50%	\$380	50%	\$380.00

The prescription plan for the Core and Plus plans has a separate \$2,000 out-of-pocket expense maximum per participant. The Plan pays 100% of a participant's eligible prescriptions for the remainder of the calendar year once the maximum is met. This \$2,000 does not go toward meeting the Core or Plus medical plans deductible or annual out-of-pocket maximums.

## SPECIALTY MEDICATIONS

Specialty medications are critical to improving the health and lives of individuals and are also some of the most expensive medications being used today. Specialty medications are typically more than \$250.00 per prescription, in an injectible or oral form, treat rare or complex diseases and typically require additional clinical support for better health outcomes.

# Medical Plans Comparison

\*ONLY IN-NETWORK COVERAGE PROVIDED UNDER THESE PLANS

	Value	Core	Plus
Annual Deductible	\$1,500/\$3,000 Single coverage/Spouse or Family	\$1,000/\$2,000	\$750/\$1,500
Co-insurance	10%	20%	20%
Out-Of- Pocket Maximum (Medical Plan Deductible counts toward out-of-pocket maximum)	\$5,000/\$10,000 Employee/Employee+Family	\$5,000/\$10,000	\$5,000/\$10,000
Physician Office Visit	10% after deductible	20% after deductible	20% after deductible
Specialist Office Visit	10% after deductible	20% after deductible	20% after deductible
After Hours Office Visit	10% after deductible	20% after deductible	20% after deductible
Physical Exams	10% after deductible	20% after deductible	20% after deductible
Gynecological Exams	10% after deductible	20% after deductible	20% after deductible
Preventative Care: Plan pays 100%. Services must be coded by your provider as preventative typically include but are not limited to well baby/child care, well woman/man care, and annual physicals.			
In-Patient Hospital	10% after deductible	20% after deductible	20% after deductible
Emergency Room	10% after deductible	20% after deductible	20% after deductible
Urgent Care Facility	10% after deductible	20% after deductible	20% after deductible
Ambulance	10% after deductible	20% after deductible	20% after deductible
Outpatient Surgery	10% after deductible	20% after deductible	20% after deductible
Mental Health: Inpatient	10% after deductible	20% after deductible	20% after deductible
Outpatient	10% after deductible	20% after deductible	20% after deductible
Radiology/Anesthesiology/Pathology/Lab Services	10% after deductible	20% after deductible	20% after deductible
Pharmacy (local and mail order)	10% after deductible	Each participant has to meet a separate \$2,000 Out of Pocket Maximum then the City pays 100% for eligible prescriptions. This \$2,000 does not count toward meeting your medical plan deductible or out of pocket maximum.	
Contraceptives - Visit <a href="http://www.myuhc.com">www.myuhc.com</a> for a complete list of covered contraceptives	100% of eligible	Co-insurance by tier: Tier 1 = 15%, Tier 2 = 25%, Tier 3 = 40%, *Tier 4 = 50% *specialty pharmacy for Core and Plus plans. 100% of eligible	

This comparison of benefits is a basic summary for the medical/pharmacy plans available to you/your family. Refer to the Summary Plan Description or the Summary of Benefits and Coverage for the complete schedule of benefits located on the Workforce Services Portal.

**\*NOTE:** All out-of-network charges are your responsibility. Therefore, if you utilize an out-of-network provider or facility, you will be responsible for 100% of those charges.

# Vision Plans

You may elect vision coverage through EyeMed. The plan pays benefits for annual exams and corrective lenses. You pay co-pays for exams, and the plan pays for frames and lenses up to certain limits. Under this plan, you may use in-network or out-of-network vision care providers, but you receive greater benefits when you use in-network providers.

The plan will pay for contacts or eyeglass lenses once every 12 consecutive months and frames once every 24 consecutive months based on the schedule of benefits.

## See Appendix A for Plan Rates.

Vision Care Services	In-network Member Cost	Out-of-network Reimbursement
Comprehensive vision exam (once every 12 months)	\$10 co-payment	UP to \$40
<b>Standard lenses</b> (once every 12 months)	\$10 co-payment (Each pair of lenses purchased through a participating EyeMed provider includes scratch-resistant coating.)*	Single vision lenses up to \$40 Bifocals up to \$60 Trifocals up to \$80 Lenticulars up to \$80
<b>Contact lenses</b> (in lieu of eyeglasses once every 12 months)	\$105 allowance*	Medically necessary up to \$210. Elective up to \$105
<b>Standard frames</b> (once every 24 months)	Most frames covered in full. May receive a \$130 allowance on frames at retail chain providers, 20% off balance over \$130 Contact EyeMed for network providers in your area.*	Up to \$80
<b>Refractive Eye Surgery for Lasik or PRK</b>	Discount at participating providers only – for provider listing visit <a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>	No benefit
*The above comparison is a summary only. Refer to the EyeMed schedule of benefits included on the Workforce Services Portal Page or <a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a> .		

# Flexible Spending Accounts (FSA)

**IMPORTANT:** YOU MUST RE-ENROLL EVERY YEAR IF you want to continue payroll deductions to any FSA plan offered by the City.

There are two types of traditional FSA accounts:

1. Health Care Account - This FSA is for health care expenses not paid by insurance, including co-insurance, exams, deductibles, vision care, dental expenses and other out-of-pocket expenses.
2. Dependent Day Care Account - This FSA is for dependent care expenses you incur to care for your eligible dependents, including daycare, afterschool care or elder care.

A third type of FSA account is the:

3. Limited Purpose (also called Limited Scope) FSA Account - This account is available to employees enrolled in the Value Medical Plan, a High Deductible Health Plan (HDHP), when an individual bank account is established for contributions to a Health Savings account.

**IMPORTANT INFORMATION:** Each FSA account is maintained as a separate account. The IRS does not allow transfers from one account to another.

Once you determine your contribution amount and complete your enrollment, a change in your contribution is not allowed unless the change is due to an IRS qualified life event. The regulations require changes to an FSA account be consistent with the life event. The City will not jeopardize the IRC Section 125 pre-tax status of these accounts due to an employee's enrollment mistake. It is the employee's responsibility to enroll in the correct FSA account so please review your elections carefully.

Following we have included the IRS website - [www.irs.gov](http://www.irs.gov). We encourage you to visit the website for additional information.

---

## FSA Health Care Account

1. Estimate your annual health care expenses not reimbursed by insurance. Examples are deductibles, co-pays, and co-insurance amounts. These expenses include all IRS eligible out-of-pocket expenses for you, your spouse and your dependent children. You are not required to enroll in any of the City's medical, dental and/or vision plans to enroll in the FSA Health Care Account. When calculating expenses, do not include payroll deduction amounts you pay for medical, dental or vision premiums. These amounts are already included as pre-tax deductions on your paycheck.
2. Decide how much money you want to contribute to the account from a minimum of \$260 to the new IRS maximum in 2014 totaling \$2,500 per year.
3. File a claim when you have eligible expenses. UnitedHealthcare medical claims are set up to process automatically. However, if you want to turn this option off, visit [www.myuhc.com](http://www.myuhc.com) and select your FSA tab, go to manage your auto rollover to stop the automatic processing of your claims.
4. You will be reimbursed for eligible claims up to the full amount you have elected for the year.

## Eligible Expenses

Some examples of expenses not covered by a medical, dental or vision care plan, AND not claimed as deductions on an income tax return AND/OR not claimed for reimbursement under any other Section 125 employer plan are:

- Deductibles, co-payments, co-insurance or fees in excess of plan limits paid by the participant and not the health plan
- Vision expenses not covered by a plan, including exams, eyeglasses, contact lenses and solutions, optometrist and ophthalmologist fees and laser eye surgery
- Dental expenses not covered by a plan including cleanings, fillings and orthodontia
- Hearing aids
- Prescription drugs
- Diabetic supplies
- Specialized equipment for disabled persons
- Physical therapy, speech therapy, and psychotherapy
- Smoking cessation programs

A more exhaustive list is located on the WFS portal or can be located in IRS Publication 502.

**NOTE:** You cannot claim an expense as a federal income tax deduction if it has been reimbursed through your FSA Account.

## Ineligible Expenses

Examples of ineligible expenses may include:

- Cosmetic expenses, toothpaste, toothbrushes and dental floss
- Face cream, moisturizers, suntan lotion, perfume, shampoos and soaps
- Vitamins
- Fees for exercise/athletic/health clubs
- Weight-loss programs for general health purposes
- Over-the-counter drugs unless you obtain a prescription from your physician.

## FSA Dependent Day Care Account

1. Estimate your dependent day care expenses for the coming year.
2. Decide how much money you want to contribute to the account from a minimum \$260 to a maximum \$5,000 per year.
3. File a claim when you have eligible dependent day care expenses.
4. You will be reimbursed for eligible claims up to the current balance available in your account.

## Eligible Expenses

You may claim dependent day care expenses for a dependent that lives with you and relies on you for more than half of their support. Dependents include:

- Children under the age of 13
- Dependent or spouse, if physically or mentally disabled and claimed on your federal income tax return

You may be reimbursed for day care only if it enables you to work or look for work. If married, your spouse must also work or be looking for work, be a full-time student or be disabled. The following are examples of eligible expenses for reimbursement.

- Expenses for pre-school and after-school child care
- Care for a child under the age of 13 at a day camp or nursery school or a private sitter
- You may be reimbursed for care provided by a relative if the person is not your spouse, child under the age of 19, or someone claimed as a dependent on your federal income tax return.

Annual limits are established and regulated by the IRS for dependent day care accounts depending on your family status. The most recent IRS Publication 503

(Taxable year 2010) includes the following limits:

<u>Status</u>	<u>Annual Limit</u>
Single.....	\$5,000
Married ..... (filing jointly)	The lesser of \$5,000, your spouse's earned income
Married ..... (filing separately)	The lesser of \$2,500, your or your spouse's earned income

Refer to IRS Publication 502 (Health) or IRS Publication 503 (Dependent Care) on the WFS Portal for a complete listing of eligible expenses.

## FSA Grace Period and Claim Submission Deadline

Effective January 1, 2007, a grace period was implemented for incurring eligible expenses. This extension gives plan participants access to FSA dollars remaining as of the 31st of December to cover eligible claims incurred January 1 through March 15 of the following year. This extension applies to both the FSA health and dependent care reimbursement plans. While this does not eliminate the use-it-or-lose-it rule completely, you have additional time to utilize your funds.

The deadline for submitting eligible claims for the plan year is May 31 of the following year. However, if you leave City employment for any reason, all FSA claims must be sent to UHC within 157 days of your date of separation from service (termination) but no later than May 31. Contributions not claimed by the deadline will be forfeited.

This account is not for a dependent health care claim reimbursements.

## Limited Purpose (limited scope) FSA (works with your HSA bank account)

This account was established by the IRS to allow individuals enrolled in a high deductible health plan, such as the City's Value Plan, to set aside pre-tax contributions for eligible **dental and vision out of pocket expenses ONLY**. Participants **must** be enrolled in the City's Value Plan and must also open an individual HSA bank account. Participants enrolled in a current FSA Health care account and/or those that have an FSA remaining in their FSA Health care account as of December 31, 2012, are not eligible to make contributions to an HSA bank account until April 1, 2013 based on current IRS regulations.

**See Appendix A for Plan Maximums**

# FSA Contributions Worksheet

Refer to IRS Publication 502 (health), 503 (dependent day care) and/or 969 (limited purpose FSA with HSA) for details regarding IRS eligibility criteria and a listing of eligible expenses.

## Health Care Contribution

Enter your annual estimated out-of-pocket expenses for each of the following. Do not include any amounts for medical, dental or vision care payroll deductions - they are automatically pre-tax deductions.

Medical (includes co-pays/co-insurance/deductibles)	\$ _____
Dental (includes co-pays/co-insurance/deductibles)	\$ _____
Vision (includes co-pays/co-insurance/deductibles)	\$ _____
Prescription drugs (includes co-insurance/deductibles)	\$ _____

(Annual election maximum = \$2,500 eff 1/1/2013)	Total	\$ _____
--------------------------------------------------	-------	----------

A health care tax deduction is available on your federal income tax return for amounts exceeding 7.5 percent of your adjusted gross income. If you think your expenses will be more than 7.5 percent, you should consult a tax advisor before using this account because you may not use the same expenses for your FSA health account and the tax deduction.

---

## Dependent Day Care Contribution

Your weekly day care costs	\$ _____	
Other eligible weekly expenses	\$ _____	
SUBTOTAL	\$ _____	
Number of weeks you will incur expenses (Multiply subtotal by number of weeks you will incur expenses)	X _____	
(Annual election maximum = \$5,000)	Total	\$ _____

A child care tax credit is available on your federal income tax return. The amount you contribute to the dependent care account reduces the tax credit you may claim. If you earn less than \$25,000, you may benefit more by using the tax credit. Consult a tax advisor.

---

## Limited Purpose Contribution

1. Must enroll in the Value (High Deductible Health Plan)
2. May be eligible to open an individual HSA Bank Account

Dental (includes co-pays/co-insurance/deductibles)	\$ _____	
Vision (includes co-pays/co-insurance/deductibles)	\$ _____	
(Annual election maximum = \$2,500)	Total	\$ _____

## Individual Health Savings Accounts (HSA)

If you enroll in the Value Medical Plan, then you may be eligible, based on current IRS regulations, to open an individual Health Savings Account (HSA) with Optum Health Bank, a United HealthGroup Bank. The Value Plan is considered a high deductible health plan under current IRS regulations.

### What are the benefits of an HSA?

- You can claim a tax deduction for contributions you, or someone other than the City, make to your HSA even if you do not itemize your deductions on Form 1040.
- The contributions remain in your account from year to year until you use them.
- The interest or other earnings on the assets in the account are tax free.
- Distributions may be tax free if you pay qualified medical expenses (IRS Publication 969).

### Do I Qualify for an HSA Account?

It is very important that you verify your eligibility to open an HSA account. The first step to determining if you are eligible is to answer the following questions:

- Are you enrolled in the City's Value Plan (a high deductible health plan)?
- If enrolled in the City's Value Plan, Is this the only medical plan you are enrolled in? (This does not apply to specific injury insurance and accident, disability, dental care, vision care and/or long term care.)
- Can you or your covered family members be claimed as a dependent on someone else's tax return?
- Are you eligible for or enrolled in Medicare?
- Are you currently enrolled in an FSA Health account? (May be enrolled in a limited purpose FSA account for dental and vision expenses only.)
- Do you qualify to make a claim from a previous FSA Health account balance due to the IRS allowed 2 -1/2 month extension provision? Example: City of Arlington has this provision. If you have or will have any balance remaining as of the 31st of December each plan year, you would not qualify to open an HSA individual bank account until the 1st of April in the year you enroll in the Value Plan.

For questions regarding HSA plan enrollment and/or eligibility, review IRS Publication 969 or contact your tax advisor.

When a participant meets the IRS eligibility requirements, he/she may choose to open an HSA (minimum contribution level for 2013 is \$10.00). Optum Health Bank is the exclusive HSA administrator for the

City of Arlington.

The bank account must be opened prior to any payroll deductions.

### How much may I contribute to the HSA?

Contribution levels change each year. The Internal Revenue Code also allows a catch-up provision for participants who attain age 55 any time in 2013. **See Appendix A for Plan Maximums.**

### May I enroll in an HSA and FSA account in the Same Year?

An individual covered by a health FSA that pays or reimburses qualified medical expenses generally cannot make contributions to an HSA. However an individual can make contributions to an HSA while covered under a high deductible health plan IF they have a limited purpose FSA. The limited purpose FSA account may be used to pay or reimburse specific items as outlined in Publication 969, which includes dental care and vision care expenses ONLY. No medical expenses can be paid from a limited purpose FSA account.

### US Patriot Act Screening Process

In 2001, in response to 9-11 terrorist attacks, the Patriot Act was created to help the government fight the funding of terrorism and money laundering activities. Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens a bank account. The act requires banks to obtain and verify a customer's name, address, and date of birth, and identification number (Social Security number) before allowing an account to accept contributions. Optum maintains a secured database, and all applicants requesting an individual HSA bank account must provide this information. Optum will notify you when the account has been approved and contributions may then begin the pay period that includes the 1st day of each month once approved.

This account belongs to you and all annual reporting is your sole responsibility. Account holders will be required to file Form 8889 with their 1040 annually. Optum provides monthly on-line statements at [www.myuhc.com](http://www.myuhc.com), an annual form 1099SA by January 31st each year, and an annual form 5498SA by May 31st each year.

### HSA Qualified Expenses

Refer to IRS Publication 969 for those expenses qualified for payment with contributions to your HSA account.

Refer to the City's website [www.arlingtontx.gov](http://www.arlingtontx.gov), the IRS website [www.irs.gov](http://www.irs.gov), Publication 969 or your tax advisor for additional HSA information.

# Retirement Plans

## Texas Municipal Retirement System (TMRS)

In lieu of Social Security, the City of Arlington provides retirement benefits for employees working in positions budgeted for at least 1,000 hours and above through TMRS. Each city chooses from a menu of retirement plan provisions. The current provisions approved by the City Council are as follows:

- Employees contribute 7% of their gross pay as a pre-tax contribution. The City matches contributions 2 -1.
- You are always 100% vested in your own contributions. You become vested in the City's contributions when you have 60 months (5 years) of service credit in the TMRS system.
- Employees may retire with 20 years of service any age or at age 60 with at least 5 years of service in the TMRS system.
- The City of Arlington has also chosen to provide Supplemental Death Benefits for members and retirees. Survivors of active employees receive an additional benefit approximately equal to the employee's annual salary. The Supplemental Death Benefits paid to a retiree's beneficiary is \$7,500.

A TMRS Benefit Guide is provided to you when you are first employed in a full-time position with the City. You will also find this guide, forms and additional information on the TMRS Website, [www.TMRS.com](http://www.TMRS.com).

### 401(k)

The City of Arlington is one of the few cities in the country that is able to offer you a 401(k) plan as part of your retirement package. This is a voluntary retirement

program and you may contribute from 1-10% of your base salary. The City matches 50% of the first 6% of your base pay. As with TMRS, you are 100% vested in your contributions to the plan from day one. The vesting schedule for the City's contribution is as follows:

Year 1.....	0%	Year 4.....	60%
Year 2.....	20%	Year 5.....	80%
Year 3.....	40%	Year 6.....	100%

All funds are invested through ICMA Retirement Corporation and there are approximately 30 funds available through the plan in which to invest. Information packets are available from Workforce Services to assist in making your investment selections.

Employees are encouraged to enroll in the 401(k) as soon as possible to maximize savings toward retirement. See Appendix A for the IRS annual year contribution limits.

### 457

In addition to the 401(k) plan, the City of Arlington offers a 457 deferred compensation plan. Like the 401(k), this is a voluntary retirement supplement vehicle that allows employees to defer taxes on current earnings, providing additional monies for retirement. You are always 100% vested in your contributions. There is no City match in the 457 plan.

All funds are invested through ICMA Retirement Corporation and there are approximately 30 funds available through the plan in which to invest.

Employees are encouraged to enroll in the 457 as soon as possible to maximize savings toward retirement. See Appendix A for current year contribution limits.

**NOTE:** For both the 401(k) and 457 plans, information packets are available from Workforce Services and ICMA-RC representatives are available to assist you with enrollment and investment fund details. You may sign up to make a contribution to these accounts at any time AND may make changes in your contribution amount at any time during the year. Enrollment and contribution changes may be completed at [www.icmarc.org](http://www.icmarc.org)

# Life Events/Family Status Change

## Life Changes Require Health Choices... Know Your Benefit Options

Knowing your benefit options means knowing the basics about health care law so you can protect yourself and your dependents. And it means finding out now about some common sense steps you can take to make sure you have the level of health care coverage you need at every stage of your life.

### Return from Approved Unpaid Leave

Employees who have been out due to an approved unpaid leave are required to re-enroll in their benefit plans within 30 days of the return to work date. Contact Workforce Services for additional information.

### Marriage

What You Need to Know: Get all the details on your spouse's plan, and be sure you understand how it works. You'll want to know the amounts of any deductibles or co-pays you will be required to pay and what you will pay for premiums.

Under the Health Insurance Portability and Accountability Act (HIPAA), you may be entitled to add yourself, a new spouse, and children to your employer's plan or to your spouse's employer's plan under a special enrollment period.

What You Need to Do: To qualify for the special enrollment period, you must notify the plan and request special enrollment for everyone enrolling within 30 days of your marriage. We require that the notice be in writing, and that is usually the safest course of action anyway.

If your spouse has health coverage available, compare the health benefits, cost, and options under both plans, then decide which one works best for you.

### Pregnancy, Childbirth, and Adoption

What You Need to Know: HIPAA places limits on the amount of time a preexisting condition exclusion period may apply. In addition, health care plans cannot consider pregnancy a preexisting condition, even if the woman did not have previous coverage.

Birth and adoption (including placement for adoption) may trigger a special enrollment period during which you, your spouse, and new dependents can enroll.

What You Need to Do: You must notify your plan and request special enrollment within 30 days of your child's birth, adoption, or placement for adoption. The

child's enrollment will be treated as occurring on the date of the birth, adoption, or placement for adoption. We require that the notice be in writing, and that is usually the safest course of action anyway.

### When Your Child is No Longer a Dependent

What You Need to Know: Once your child "ages out" under your health care plan's rules, the child may be eligible to purchase temporary extended health care coverage for up to 36 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

What You Need to Do: Once your covered child is no longer a dependent, notify your employer in writing within 60 days. In turn, your plan should notify your child of his or her right to extend health care benefits under COBRA. Your child will have 60 days from the date the notice was sent to elect COBRA coverage. The cost will be higher, since the total plan cost will be included as the City will no longer pay a portion. COBRA costs are posted on the Workforce Services portal under the category of COBRA.

### Death, Legal Separation, or Divorce

What You Need to Know: When an employee covered under an employer-sponsored health plan dies, or divorces, the covered spouse and dependent children may be eligible to purchase temporary extended health care coverage for up to 36 months. The cost will be higher, since the total plan cost will be included as the City will no longer pay a portion. COBRA costs are posted on the Workforce Services portal under the category of COBRA.

If the spouse losing coverage under the City plan has a health plan available through his or her employer, the spouse and any dependents may be eligible to obtain coverage through special enrollment with their employer.

If the covered employee dies or in the event of a divorce, the plan should notify the covered spouse and dependent children of their right to purchase extended health care coverage under COBRA. Most plans require eligible individuals to make their COBRA election of coverage within 60 days of the plan's notice.

What You Need to Do: Should the employee who is covered by the health care plan die, the employer must notify the healthcare plans within 30 days. If there is a divorce or legal separation, the covered employee, spouse, or dependent children must notify the plan in writing within 60 days. In case of death of the covered employee or divorce the plan will then notify the eligible spouse and dependent children who would

lose coverage under the plan of their right to purchase temporary extended health care coverage. Enrollment is required within 60 days of the COBRA notice date.

If the spouse losing coverage under the plan has a health plan available through his or her employer, the spouse and dependent children may be eligible for a special enrollment under that plan. To qualify, the spouse must notify that plan and request special enrollment within 30 days of the loss of coverage.

### Summary of COBRA Qualifying Events, Qualified Beneficiaries, and Maximum Periods of Continuation Coverage

The following chart shows the specific qualifying events, the qualified beneficiaries who are entitled to elect continuation coverage, and the maximum period of continuation coverage that must be offered, based on the type of qualifying event. Note that an event is a qualifying event only if it would cause the qualified beneficiary to lose coverage under the plan.

COBRA Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination (for reasons other than gross misconduct), reduction in hours of employment (FT to PT), or unpaid leaves	Employee Spouse Dependent Child	18 months(2)
Employee enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

### LIFE EVENTS

You may be allowed to change your coverage level during the plan year due to the loss of other coverage, or for one of the following reasons:

- You marry or divorce;

- You gain a dependent due to birth, adoption, placement for adoption, eligibility under a Qualified Medical Child Support Order, legal guardianship, or lose a dependent due to ineligibility or death;
- You or your spouse obtains or loses a job which changes eligibility for coverage;
- You or your spouse experiences a significant change in employment status (for example, going from full-time to part-time) which changes eligibility for coverage;
- Your child is no longer eligible because of the plan's limiting age; or
- You or your spouse take or return from an unpaid leave of absence that affects coverage.

### YOUR SPECIAL ENROLLMENT RIGHTS

You, your spouse, or your children may be entitled to enroll in the medical, dental and vision plans at times other than annual open enrollment. Generally, you may enroll in these plans when:

- Other coverage ends because you or your dependents are no longer eligible;
- You or your dependent exhaust COBRA coverage under another employer's plan;
- You gain a dependent, you marry, have a new child by birth or adoption, or a child is placed with you for adoption;
- The employer sponsoring the other coverage is no longer making contributions toward the cost of coverage.

\* If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance program (CHIP) coverage and you request enrollment **within 60 days** after that coverage ends; or

\*If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and your request enrollment **within 60 days** after the determination of eligibility for such assistance.

Note: The 60 day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a **30 day period** applies to most special enrollments. **Please forward all required** documentation to the Workforce Services department.

**On-Line Entry Requirement** – Most changes would be completed on-line through Employee Self Service to include birth, adoption, marriage, changes in employment for a spouse, and divorce. However,

notifications of a death or a child reaching age 26 should be reported directly to Workforce Services.

**Most changes/notifications must be made within 30 days of the life event.** Changes in coverage will not be processed until the request for change in benefits has been reviewed and the required documentation has been provided to Workforce Services.

**Proof Requirement** – Documentation for a mid-year benefit plan change due to a life event must be provided to Workforce Services **within 30 days of the event.** Typical documentation would include the name and date of birth of the family member who has either gained or

lost coverage and the effective date of the gain or loss of coverage. Document examples include, but are not limited to COBRA notices, Certificate of Healthcare Coverage forms, employer letterhead outlining the details including the date of gain or loss of specific coverage.

**Warning:** *Any intentional false statement in your enrollment or willful misrepresentation relative thereto is a violation of City policy subject to disciplinary action and/or financial restitution.*

---

## Employee Assistance Program - CARE-24

The City of Arlington provides full-time employees with an employee assistance program. These services are provided through United HealthCare's Care-24 services. Care-24 services offer you access to a wide range of health and well-being information – seven days a week, 24 hours a day. Using one toll-free phone number, you can speak with registered nurses and master's level counselors who can help with almost any problem ranging from medical and family matters to personal legal, financial, and emotional needs.

When you call the same toll-free number, you can listen to audio messages on more than 1,100 health and

well-being topics. If face-to-face resources are more appropriate for your situation, a Care-24 representative may refer you to local, in-person support. Counselors may refer you to a wide range of national and community resources.

Care-24 nurses and counselors help you and your families identify and address concerns that span the spectrum of work and life.

To take advantage of Care-24 services, nurses and counselors are available 24 hours a day, 7 days a week. Call 1-888-887-4114.

# Additional Voluntary Plans

See Appendix C for rate charts.

## Cigna Short Term Disability Plan

If you were out of work due to a sickness or injury, how would you pay the bills? The Short Term Disability insurance plan is designed to replace a portion of lost income when a sickness or injury limits your ability to work and earn a full paycheck. **Covers you on the job and off the job!**

Benefits begin on 15th day of a qualifying disability and may be paid up to 16 weeks! Benefit choices of 40%, 50% or 60% of weekly covered earnings up to a \$1,250 maximum benefit per week! Benefits are not payable for any disability resulting from a pre-existing condition.

## MetLife Critical Illness Plan

MetLife Critical Illness Insurance provides you with a lump-sum benefit payment of \$10,000 in the event you or your covered dependent experience one of the covered medical conditions:

- Category 1 incorporates certain cancer-related conditions: Full Benefit Cancer, Partial Benefit Cancer\* and Bone Marrow Transplant
- Category 2 incorporates certain heart-related conditions: Heart Attack, Heart Transplant, Stroke and Coronary Artery Bypass Graft\*
- Category 3 incorporates certain other covered conditions: Major Organ Transplant (other than bone marrow and heart) and Kidney Failure

Current employees are required to complete a SOI to enroll.

## SISLINK Medical Gap Plan

A deductible and coinsurance program designed to offset out of pocket expenses. An employee benefit designed to supplement the group medical program for employees and their dependents. No Sol required, no pre-existing conditions are excluded.

Eligible expenses must:

- be medically necessary and result from the treatment of an injury or an illness;
- be covered by your comprehensive major medical plan; and
- be applied by your major medical plan to your deductible or coinsurance provision.

### Two Benefits Provided:

**In Hospital:** For hospital stays, this benefit pays up to the maximum amount purchased per person per year for amounts the medical plan allocates to deductible or coinsurance

**Outpatient Services:** Up to the maximum amount purchased, up to 4 times per family per year for eligible out-patient services that are allocated to deductible and coinsurance by the medical plan.

	Plan 1:	Plan 2:	Plan 3:
In Hospital:	\$1,000	\$2,000	\$3,000
Out-Patient:	\$500	\$1,000	\$1,500

# Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

## Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

## Appeal

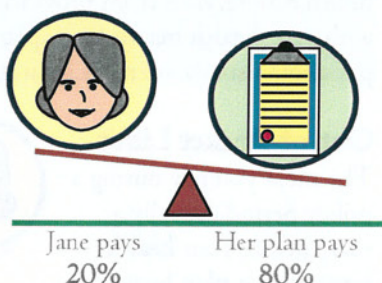
A request for your health insurer or **plan** to review a decision or a **grievance** again.

## Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

## Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



(See page 4 for a detailed example.)

## Complications of Pregnancy

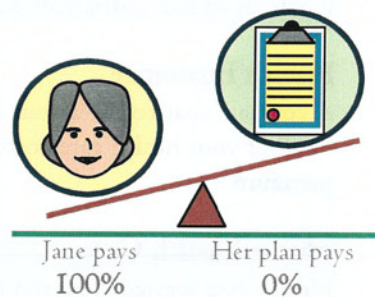
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

## Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

## Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

## Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

## Emergency Room Care

**Emergency services** you get in an emergency room.

## Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

## Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

## Grievance

A complaint that you communicate to your health insurer or **plan**.

## Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

## Home Health Care

Health care services a person receives at home.

## Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

## In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

## In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

## Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

## Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

## Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

## Out-of-network Co-insurance

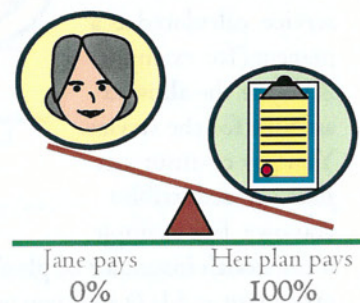
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

## Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

## Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

## Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

## Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

## Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

## Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

## Prescription Drug Coverage

**Health insurance** or **plan** that helps pay for **prescription drugs** and medications.

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

## Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

## Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

## Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

## Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

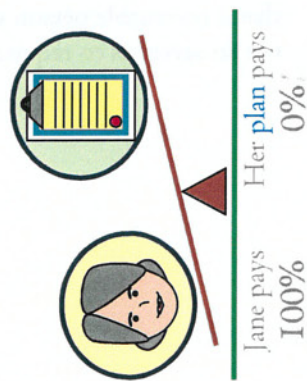
## Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

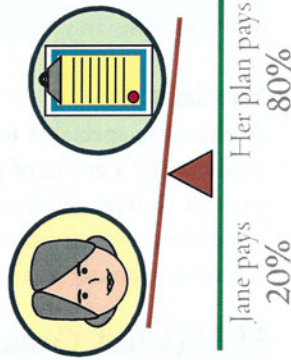
# How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500      Co-insurance: 20%      Out-of-Pocket Limit: \$5,000

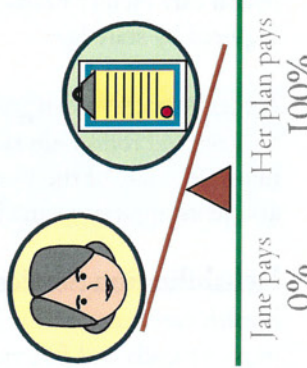
January 1<sup>st</sup>  
Beginning of Coverage  
Period



**Jane hasn't reached her \$1,500 deductible yet**  
Her plan doesn't pay any of the costs.  
Office visit costs: \$125  
Jane pays: \$125  
Her plan pays: \$0



**Jane reaches her \$1,500 deductible, co-insurance begins**  
Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.  
Office visit costs: \$75  
Jane pays: 20% of \$75 = \$15  
Her plan pays: 80% of \$75 = \$60



**Jane reaches her \$5,000 out-of-pocket limit**  
Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.  
Office visit costs: \$200  
Jane pays: \$0  
Her plan pays: \$200

December 31<sup>st</sup>  
End of Coverage Period

# GENERAL NOTICE

## Continuation Coverage Rights Under COBRA

### Introduction

You are receiving this notice because you have recently become covered under The City of Arlington Texas group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It may also become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, (Examples: status change from FT to PT, unpaid leave of absence (other than up to 12 weeks when on approved Family Medical leave), or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a bankruptcy proceeding under title 11 of the United States Code can be a qualifying event. If a proceeding bankruptcy is filed with respect to The City of Arlington Texas, and that bankruptcy results in loss of coverage for any retired employee under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become qualified beneficiaries if bankruptcy results in loss of their coverage under the Plan.

### When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction in hours of employment, death of the employee, commencement of a bankruptcy proceeding with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

### You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: City of Arlington Texas, Attention: Workforce Services, 101 S. Mesquite – Suite 790, PO Box 90231, MS 63-0790, Arlington, TX 76004-3231. If the qualifying event is divorce you will need to provide a copy of the executed decree as documentation of the date of the divorce or legal separation.

## **How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months (36 months minus 8 months) after the date of the qualifying event. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family might be entitled to receive an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Plan Administrator of the second qualifying event within 60 days of a second qualifying event. Notice must be sent to: City of Arlington Texas, Attention: Workforce Services, 101 S. Mesquite – Suite 790, PO Box .90231, MS 63-0790, Arlington, TX 76004-3231. Please include a copy of your Social Security Determination letter.

### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension can become available to the spouse and dependent children receiving coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if this second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event occurred. In all of these cases, you must notify the Plan Administrator of the second qualifying event within 60 days of this second qualifying event. Notice must be sent to: City of Arlington Texas, Attention: Workforce Services, 101 S. Mesquite – Suite 790, PO Box 90231, MS 63-0790, Arlington, TX 76004-3231. Please include a copy of the death certificate, Medicare card(s) or divorce/legal separation decree as applicable.

### **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contacts identified in the next section of this notice. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep, for your records, a copy of any notices you send to the Plan Administrator.

### **Plan Contact Information**

The Plan Administrator is City of Arlington Texas 817.459.6869. The Plan Administrator is responsible for administering COBRA continuation coverage. The City of Arlington, Texas has contracted with United Healthcare to administer COBRA continuation coverage. All COBRA elections are sent directly to United Healthcare. Questions regarding COBRA elections and payments may be directed to United Healthcare's Customer Service 1.866.747.0048.

*Update October 20, 2012*

# Important Notice from the City of Arlington About Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Arlington and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Arlington has determined that the prescription drug coverage offered by the United Healthcare Medco Pharmacy Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## **What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you are an active employee or a dependent of an active employee eligible to join a Medicare drug plan and you enroll in a Medicare drug plan, your Medco

Pharmacy Plan coverage will end. Active employees and/or their dependents eligible for Medicare are not required to enroll in another Medicare Part D pharmacy plan and may remain in the Medco Pharmacy Plan only if not enrolled in a Medicare part D plan. For those active employees who elect Part D coverage, the city's Medco Pharmacy Plan will end for the employee and all covered dependents. The City's Medco Pharmacy plan does provide creditable pharmacy coverage.

Retirees and/or their dependents eligible for Medicare AND age 65 are not required to enroll in the UnitedHealthcare Medicare Part D pharmacy plan. However, pharmacy coverage ends in the Medco Pharmacy Plan upon attainment of age 65. The City offers the UnitedHealthcare Medicare Part D plan as a post 65 pharmacy option. Pre-65 retirees and/or dependents not eligible for Medicare may enroll in the Medco Pharmacy Plan.

If you do decide to join a Medicare drug plan and drop your current Medco Pharmacy plan through the City of Arlington, be aware that you and your dependents will not be able to get this coverage back.

NOTE: See the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at [www.cms.hhs.gov/CreditableCoverage/](http://www.cms.hhs.gov/CreditableCoverage/)), which outlines the prescription drug plan provisions/options available to Medicare eligible individuals that are eligible for Medicare Part D.

## **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with the City of Arlington and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information or call United Healthcare at 1.866.844.4867 regarding your United Healthcare Medco Pharmacy Plan. NOTE: You'll get this notice each year. You will also get it before the next open enrollment period when you can join a Medicare drug plan and if this coverage through the City's Medco Pharmacy Plan changes. You may view this notice on the City's website located at [www.arlingtontx.gov](http://www.arlingtontx.gov). (Refer to Retirees / City Benefits) You also may request a copy of this notice at any time.

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

### **For more information about Medicare prescription drug coverage:**

- ☐ Visit [www.medicare.gov](http://www.medicare.gov)
- ☐ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- ☐ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember:** Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 09/21/2011

Name of Entity/Sender: City of Arlington

Contact--Position/Office:

Workforce Services

Address: PO Box 90231  
MS 63-0790  
Arlington, TX  
76004-3231

Phone Number: 817.459.6869

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS Form 10182-CC

Updated October 5, 2011

# **REQUIRED NOTICE: UnitedHealthcare Annual Rights and Resource Disclosure Notice**

Visit [www.myuhc.com/uhcrights](http://www.myuhc.com/uhcrights) to view the Annual Rights and Resource Disclosure Notice. This document will inform you about:

- Finding a network physician or hospital
- Obtaining routine, preventive and specialty care; urgent, ER and hospital care; after-hours, out-of-state/area and behavioral health care
- Notification requirements and medical services, financial incentives and evaluation of new technology
- Case and Disease Specific Management
- Benefit coverage, exclusions, restrictions, and costs of care; Pharmacy procedures and benefits
- Looking up claims/Obtaining an ID card
- How to voice a complaint or submit an appeal
- Quality improvement program results
- Your rights and responsibilities as a member
- Women's Health and Cancer Rights Act/Newborns' and Mothers' Health Protection Act
- Notice of Privacy Practices
- Language assistance services

The City's plan also includes behavioral health benefits for the following participants:

- Active/Retiree/COBRA participants enrolled in the Value, Core or Plus medical plans but choose plans with the City of Arlington
- Active employees eligible for the Value, Core or Plus medical plans but choose to waive this coverage through the City
- COBRA participants enrolled in EAP - Employee Assistance Program

Additional information about United Behavioral Health is available at: [www.liveandworkwell.com/WellnessMatters](http://www.liveandworkwell.com/WellnessMatters). To request a paper copy, call the toll-free member phone number on your ID card.

Log into [www.myuhc.com/uhcrights](http://www.myuhc.com/uhcrights) to view the Annual Rights & Resource Disclosure. If you do not have internet access, contact Workforce Services 817-459-6869 to request a paper copy be mailed to your home address.

Reviewed 10/20/12

# Health Care Reform Required Notice

Effective January 1, 2011, under the Patient Protection and Affordable Care Act (the Affordable Care Act), City of Arlington is required to provide the following notice and disclosure regarding primary care providers (PCP) and pediatricians as PCP for a child. Also included in the required notices below is information regarding OB/GYN providers, prior authorization and referral information.

## Designation of a Primary Care Provider

The City of Arlington health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the UnitedHealthCare network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UnitedHealthCare at the phone number included on your medical card or complete a provider search on [www.myuhc.com](http://www.myuhc.com).

For children, you may designate a pediatrician as the primary care provider.

## Access to Obstetrical or Gynecological Care

You do not need prior authorization from United Healthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the UHC network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participant health care professions who specializes in obstetrics or gynecology, contact United Healthcare at the phone number included on your medical card or complete a provider search on [www.myuhc.com](http://www.myuhc.com).

Effective January 1, 2011, under the Patient Protection and Affordable Care Act (the Affordable Care Act),

the City of Arlington may not offer a medical plan that includes an individual lifetime maximum benefit. The City of Arlington health (Core/ Plus/ Value) plans do not include individual lifetime maximum benefits. However, we are required to provide you with the following Notice:

## Lifetime Limit No Longer Applies and Enrollment Opportunity Notification

The lifetime limit on the dollar value of benefits under the City of Arlington medical plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice for more information contact Workforce Services to request re-enrollment.

Effective January 1, 2011, under the Patient Protection and Affordable Care Act (the Affordable Care Act), the City of Arlington will extend dependent coverage for employee/retiree dependents up until they are 26. The City's previous policy included dependents up until they are 25. Following is the required Notice regarding this change:

## Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before the attainment of age 26 are eligible to enroll in a City of Arlington medical, dental and/or vision plan. Individuals may request enrollment for such children during the annual open enrollment period. Enrollment will be effective January 1st, 2013. For more information contact Workforce Services 817.459.6869.

**Find additional information about the Affordable Care Act at [www.dol.gov/ebsa/healthreform/](http://www.dol.gov/ebsa/healthreform/)**

# Other Required Notices

## Maternity Coverage

For maternity stays, in accordance with federal law, the plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean delivery. However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a cesarean delivery).

## Pre-existing Condition Limitation

Effective January 1, 2013, the City's medical plans no longer include a pre-existing condition exclusion for adults or children.

## Women's Health and Cancer Rights

On October 21, 1998, Congress passed a bill called the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymphedemas

In addition, the plan may not:

- interfere with a woman's rights under the plan to avoid these requirements, or
- offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law. However, the plan may apply deductibles and copays consistent with other coverage provided by the plan. If you have questions about the current plan coverage, please contact UnitedHealthCare by calling the phone number provided on your Medical ID Card.

# CHIPRA Notice

## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP

office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid Website: <a href="http://www.medicaid.alabama.gov">www.medicaid.alabama.gov</a> Phone: 1-855-692-5447	COLORADO – Medicaid Medicaid Website: <a href="http://www.colorado.gov/">www.colorado.gov/</a> Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA - Medicaid Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a> Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	FLORIDA – Medicaid Website: <a href="http://www.flmedicaidtprecovery.com/">www.flmedicaidtprecovery.com/</a> Phone: 1-877-357-3268
ARIZONA - CHIP Website: <a href="http://www.azahcccs.gov/applicants/">www.azahcccs.gov/applicants/</a> Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	GEORGIA – Medicaid Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP Medicaid Website: <a href="http://www.accesstohealthinsurance.idaho.gov">www.accesstohealthinsurance.idaho.gov</a> Medicaid Phone: 1-800-926-2588 CHIP Website: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a> CHIP Phone: 1-800-926-2588	MONTANA – Medicaid Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a> Phone: 1-800-694-3084
INDIANA - Medicaid Website: <a href="http://www.in.gov/fssa">www.in.gov/fssa</a> Phone: 1-800-889-9949	NEBRASKA – Medicaid Website: <a href="http://www.accessnebraska.ne.gov">www.accessnebraska.ne.gov</a> Phone: 1-800-383-4278
IOWA - Medicaid Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562	NEVADA - Medicaid Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900
KANSAS - Medicaid Website: <a href="https://www.kdheks.gov/hcf/">https://www.kdheks.gov/hcf/</a> Phone: 1-800-792-4884	NEW HAMPSHIRE – Medicaid Website: <a href="http://www.dhhs.nh.gov/oii/documents.hippahp.pdf">www.dhhs.nh.gov/oii/documents.hippahp.pdf</a> Phone: 603-271-5218

KENTUCKY - Medicaid Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570	NEW JERSEY – Medicaid and CHIP Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 1-800-356-1561 CHIP Website: <a href="http://www.njfamilycare.org/index.html">www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
LOUISIANA - Medicaid Website: <a href="http://www.lahipp.dhh.louisiana.gov">www.lahipp.dhh.louisiana.gov</a> Phone: 1-866-695-2447	
MAINE - Medicaid Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">www.maine.gov/dhhs/ofi/public-assistance/index.html</a> Phone: 1-800-977-6740 TTY: 1-800-977-6741	NEW YORK – Medicaid Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">www.nyhealth.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP Website: <a href="http://www.mass.gov/MassHealth">www.mass.gov/MassHealth</a> Phone: 1-800-462-1120	NORTH CAROLINA – Medicaid Website: <a href="http://www.ncdhhs.gov/dma">www.ncdhhs.gov/dma</a> Phone: 919-855-4100
MINNESOTA – Medicaid Website: <a href="http://www.dhs.state.mn.us/">www.dhs.state.mn.us/</a> Click on Health Care, then Medical Assistance Phone: 800-657-3629	NORTH DAKOTA – Medicaid Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-800-755-2604
MISSOURI - Medicaid Website: <a href="http://www.dss.mo.gov/mhd/index.htm">www.dss.mo.gov/mhd/index.htm</a> Phone: 573-751-2005	UTAH – Medicaid and CHIP Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a> Phone: 1-866-435-7414
OKLAHOMA – Medicaid and CHIP Website: <a href="http://www.insureoklahoma.org">www.insureoklahoma.org</a> Phone: 1-888-365-3742	VERMONT – Medicaid Website: <a href="http://greenmountaincare.org/">http://greenmountaincare.org/</a> Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP Website: <a href="http://www.oregonhealthykids.gov">www.oregonhealthykids.gov</a> <a href="http://hijossaludablesoregon.gov">http://hijossaludablesoregon.gov</a> Phone: 1-877-314-5678	VIRGINIA – Medicaid and CHIP Medicaid Website: <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">www.dmas.virginia.gov/rcp-HIPP.htm</a> Medicaid Phone: 1-800-432-5924 CHIP Website: <a href="http://www.famis.org/">www.famis.org/</a> CHIP Phone: 1-866-873-2647
PENNSYLVANIA - Medicaid Website: <a href="http://www.dpw.state.pa.us/hipp">www.dpw.state.pa.us/hipp</a> Phone: 1-800-692-7462	WASHINGTON – Medicaid Website: <a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a> Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND - Medicaid Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a> Phone: 401-462-5300	WEST VIRGINIA – Medicaid Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a> Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH CAROLINA – Medicaid Website: <a href="http://www.scdhhs.gov">www.scdhhs.gov</a> Phone: 1-888-549-0820	WISCONSIN – Medicaid Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">www.badgercareplus.org/pubs/p-10095.htm</a> Phone: 1-800-362-3002
SOUTH DAKOTA – Medicaid Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	WYOMING - Medicaid Website: <a href="http://www.health.wyo.gov/healthcarefin/equalitycare">www.health.wyo.gov/healthcarefin/equalitycare</a> Telephone: 307-777-7531
TEXAS - Medicaid Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a> Phone: 1-800-440-0493	

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)  
Ext. 61565

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
Error! Hyperlink reference not valid. 1-877-267-2323,

OMB Control Number 1210-0137 (expires 09/30/2013)

## 2013 Benefit Cost and Plan Limits

<b>Bi-Weekly MetLife Dental Plan Cost:</b>				<b>Bi-Weekly EyeMed Vision Plan Cost:</b>	
Coverage Level	DHMO	Low PPO	High PPO	Coverage Level	Cost per pay period
Employee Only	\$5.04	\$6.50	\$15.68	Employee Only	\$2.07
Employee + 1	\$9.56	\$12.88	\$31.04	Employee + 1	\$4.34
Employee + Family	\$14.34	\$22.67	\$54.63	Employee + Family	\$6.61

*\*NOTE: Biweekly deductions may differ each paycheck due to rounding of the annual rate.*

<b>Bi-Weekly Medical Plan Costs:</b>		Employee Bi-Weekly	Employee Annually
<b>Core Plan</b>	Employee Only	\$14.73	\$381.04
	Employee + Child or Children	\$56.72	\$1,474.68
	Employee + Spouse	\$68.68	\$1,784.88
	Employee + Family	\$105.34	\$2,738.76
<b>Plus Plan</b>	Employee Only	\$39.80	\$1,034.76
	Employee + Child or Children	\$107.44	\$2,793.36
	Employee + Spouse	\$126.37	\$3,285.60
	Employee + Family	\$185.27	\$4,817.04
<b>Value Plan</b>	Employee Only	\$ 5.08	\$ 132.00
	Employee + Child or Children	\$ 13.50	\$351.00
	Employee + Spouse	\$ 19.40	\$504.48
	Employee + Family	\$ 37.57	\$976.80

*NOTE: Biweekly deductions may differ each paycheck due to rounding of the annual rate.*

<b>Health Savings Account Limits</b>		<b>HSA Limited Scope FSA</b>	
Individual	\$3,250	*IRS requires you be enrolled in a high deductible health plan (HDHP) to establish an individual bank account for which you may elect pre-tax payroll deductions. The Value medical plan is a HDHP. You may not be enrolled in the FSA Health account if you are making contributions to an individual HSA bank account. Questions regarding IRS regulations should be directed to the IRS or your Tax Advisor.	
Families	\$6,450		
Age 55 Catch-up (if other contribution maxed)	\$1,000		
<b>Flexible Spending Account Limits (FSA)</b>		<b>Retirement Account Limits 2013</b>	
Over-the-counter meds not covered w/o a prescription		401(k) annual limit	\$17,500
FSA Health (medical, dental & vision expenses)	\$2,500	401(k) Age 50 Catch-up	\$5,500
FSA Dependent Day Care (day care expenses)	\$5,000	457 annual limit	\$17,500
		457 Age 50 Catch-up	\$5,500

## 2013 Life Insurance Biweekly Rates - Employee

Issued by CIGNA Rates Effective: January 1, 20113

Optional Term Life and Accidental Life & Dismemberment Insurance – Biweekly Cost per Coverage Amount – Employee Coverage is available in increments of \$10,000 with a minimum of \$20,000, up to the lesser of 8 times Base Annual Earnings, rounded to the next higher \$1,000 or to a maximum \$500,000. Refer to the Optional Term Life section for evidence of insurability details. Initial rates based on age as of effective date of your coverage. Rates change January 1st each year based on your age at that time.

Employee Optional Life and AD&D Insurance												
Age	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000	\$150,000	\$200,000	\$250,000
< 25	\$0.78	\$1.18	\$1.57	\$1.96	\$2.35	\$2.75	\$3.14	\$3.53	\$3.92	\$5.88	\$7.85	\$9.81
25-29	\$0.86	\$1.29	\$1.72	\$2.15	\$2.58	\$3.00	\$3.43	\$3.86	\$4.29	\$6.44	\$8.58	\$10.73
30-34	\$0.94	\$1.41	\$1.88	\$2.35	\$2.82	\$3.30	\$3.77	\$4.24	\$4.71	7.06	\$9.42	\$11.77
35-39	\$1.10	\$1.65	\$2.20	\$2.75	\$3.30	\$3.84	\$4.39	\$4.94	\$5.49	\$8.24	\$10.98	\$13.73
40-44	\$1.1.50	\$2.24	\$2.99	\$3.74	\$4.49	\$5.23	\$5.98	\$6.73	\$7.48	\$11.22	\$14.95	\$18.69
45-49	\$2.28	\$3.42	\$4.56	\$5.70	\$6.84	\$7.98	\$9.12	\$10.26	\$11.40	\$17.10	\$22.80	\$28.50
50-54	\$3.62	\$5.43	\$7.24	\$9.05	\$10.86	\$12.66	\$14.47	\$16.28	\$18.09	\$27.14	\$36.18	\$45.23
55-59	\$5.27	\$7.91	\$10.54	\$13.18	\$15.81	\$18.45	\$21.08	\$23.72	\$26.35	\$39.53	\$52.71	\$65.88
60-64	\$7.80	\$11.70	\$15.60	\$19.50	\$23.40	\$27.30	\$31.20	\$35.10	\$39.00	\$58.50	\$78.00	\$97.50
65-69	\$11.37	\$17.06	\$22.74	\$28.43	\$34.12	\$39.80	\$45.49	\$51.18	\$56.86	\$85.29	\$113.72	\$142.15
70-74	\$44.54	\$66.81	\$89.08	\$111.35	\$133.62	\$155.88	\$178.15	\$200.42	\$222.69	\$334.04	\$445.38	\$556.73
75+	\$149.83	\$224.75	\$299.67	\$374.58	\$449.50	\$524.42	\$599.34	\$674.25	\$749.17	\$1,123.75	\$1,498.34	\$1,872.92

NOTE: Evidence of Insurability required for employee supplemental coverage above the guaranteed issue amount \$200,000. Cost of insurance for all coverages, which are deducted from your paycheck, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to these coverages are governed by the Certificate. Rates may be subject to change.

## 2013 Life Insurance Biweekly Rates - Spouse

Issued by CIGNA Rates Effective: January 1, 2013

Optional Dependent Term Life – Biweekly Cost per Coverage Amount – Coverage is available for your spouse in increments of \$5,000 with a minimum of \$10,000 to \$150,000, not to exceed 50% of the employee's Optional Term Life coverage amount. Refer to the Dependent Term Life section for evidence of insurability details. Initial rates based on spouse's age as of the effective date of coverage. Rates change January 1st each year based on your spouse's age at that time.

Spouse Optional Life Insurance**												
Age	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000	\$75,000	\$100,000	\$125,000
< 25	\$0.28	\$0.42	\$0.55	\$0.69	\$0.83	\$0.97	\$1.11	\$1.25	\$1.38	\$2.08	\$2.77	\$3.46
25-29	\$0.31	\$0.47	\$0.63	\$0.78	\$0.94	\$1.10	\$1.26	\$1.41	\$1.57	\$2.35	\$3.14	\$3.92
30-34	\$0.36	\$0.53	\$0.71	\$0.89	\$1.07	\$1.24	\$1.42	\$1.60	\$1.78	\$2.67	\$3.55	\$4.44
35-39	\$0.43	\$0.65	\$0.87	\$1.08	\$1.30	\$1.52	\$1.74	\$1.95	\$2.17	\$3.25	\$4.34	\$5.42
40-44	\$0.63	\$0.95	\$1.26	\$1.58	\$1.90	\$2.21	\$2.53	\$2.85	\$3.16	\$4.74	\$6.32	\$7.90
45-49	\$1.02	\$1.54	\$2.05	\$2.56	\$3.07	\$3.59	\$4.10	\$4.61	\$5.12	\$7.68	\$10.25	\$12.81
50-54	\$1.69	\$2.54	\$3.39	\$4.23	\$5.08	\$5.93	\$6.78	\$7.62	\$8.47	\$12.70	\$16.94	\$21.17
55-59	\$2.52	\$3.78	\$5.04	\$6.30	\$7.56	\$8.82	\$10.08	\$11.34	\$12.60	\$18.90	\$25.20	\$31.50
60-64	\$3.78	\$5.68	\$7.57	\$9.46	\$11.35	\$13.25	\$15.14	\$17.03	\$18.92	\$28.38	\$37.85	\$47.31
65-69	\$5.57	\$8.36	\$11.14	\$13.93	\$16.71	\$19.50	\$22.28	\$25.07	\$27.85	\$41.78	\$55.71	\$69.63
70+ not available												

\*\*Spouse rate is based on spouse's date of birth.

Child Optional Life Insurance		
Insurance Amount	Annual Rate	Bi-weekly Rate
\$10,000	\$21.60	\$0.83

**NOTE:** Once enrolled, the payroll deduction will automatically increase as you move to a new age band each January 1st each year.  
*Biweekly payroll deduction may differ due to rounding.  
 Above rates are estimates.*

## Other Voluntary Plan Rates

<b>*Examples of Bi-Weekly Short Term Disability Rates</b>			
Annual Salary	Benefit %	Rate	Bi-Weekly Payroll Deduction - 2013
\$20,000	60%	\$0.48	\$5.11
\$20,000	50%	\$0.48	\$4.25
\$20,000	40%	\$0.48	\$3.41
\$50,000	60%	\$0.48	\$12.78
\$50,000	50%	\$0.48	\$10.65
\$50,000	40%	\$0.48	\$8.52

Calculation Example: Weekly Salary x 40%, 50%, or 60% (multiplied by \$0.48/\$10) = Monthly Premium

<b>*Examples of Bi-Weekly Critical Illness Rates</b>			
Employee Issue Age	\$10,000	Spouse Issue Age	\$10,000
<25	\$0.69	< 25	\$0.69
25 -29	\$0.78	25 -29	\$0.83
30 - 34	\$1.34	30 - 34	\$1.38
35 – 39	\$2.35	35 – 39	\$2.40
40 - 44	\$3.92	40 - 44	\$3.97
45 - 49	\$6.65	45 - 49	\$6.55
50 - 54	\$10.71	50 - 54	\$10.11
55 - 59	\$16.94	55 - 59	\$15.42

Dep Child/Children-\$0.35

<b>*Examples of Bi-Weekly Medical Gap Rates</b>			
<b>Under Age 40</b>	PLAN 1	PLAN 2	PLAN 3
Insured Only	\$6.78	\$9.31	\$13.35
Insured plus Spouse	\$12.20	\$16.77	\$24.03
Insured plus Child(ren)	\$16.72	\$22.38	\$32.51
Insured plus Family	\$22.13	\$29.81	\$43.17

Refer to the Workforce Services Portal Page for more examples of rates.

# Important Contacts

HEALTH PLANS			
UNITEDHEALTHCARE Group #702632	Medical - Core & Plus Value HDHP	1-866-633-2446 1-866-314-0335	www.myuhc.com
UHC CARE-24 Program	EAP - Employee Assistance Plan	1-888-887-4114	www.liveandworkwell.com
METLIFE DENTAL	DHMO-Plan SGX245-TX PPO Plans-#0146053	1-800-880-1800 1-800-942-0854	www.metlife.com/mybenefits
EYEMED SELECT NETWORK	Vision (Pre-Enrollment Questions – 1-866-299-1358)	1-866-723-0514	www.eyemedvisioncare.com
Flexible Spending Accounts			
UNITEDHEALTHCARE Group #707191	Health Dependent Day Care Limited Scope (HSA)	1-800-331-0480 Claims Fax: 1.915.231.1709 or 1.866.262.6354	www.myuhc.com
Health Savings Account			
OPTUMHEALTHBANK	Individual HSA Account	1-800-791-9361	www.myuhc.com
Optional Supplemental Payroll Deduction Plans			
METLIFE	Critical Illness Policy	1-800-438-6388 1-800-GETMET8	N/A
CIGNA	Short Term Disability		
SISLINK	Medical Gap Policy	972.788.0699 1.800.767.6811	customerservice@specialinc.com
Retirement Plans			
TMRS - City #00052 (Texas Municipal Retirement System)	Retirement Program	1-800-924-8677	www.tmrs.com
ICMA-RC Plan # 106061 Plan # 301966	401(k) Thrift Savings Plan 457 Savings Plan	1-800-669-7400	www.icmarc.com
Mike Mendenhall ICMA-RC Consultant	Enrollment Assistance Retirement Planning	1-800-290-7160	mmendenhall@icmarc.org
Karen Gordon IMCA-RC Consultant	Enrollment Assistance Retirement Planning	1-866-886-8023	kgordon@icmarc.org

Workforce Services Department  
City Tower, Seventh Floor  
101 S. Mesquite St., Suite 790 • Arlington, TX 76010 • 817-459-6869

Additional information and benefit links will be found on the Workforce Services Portal